SENATE FISCAL AGENCY
ISSUE PAPER

MEDICAID AND MICHIGAN HOSPITALS

A LOOK BEHIND THE NUMBERS

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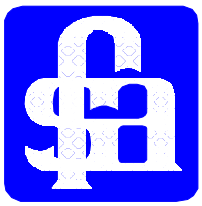
March 2000



A Series of Papers Examining Critical Issues Facing the Michigan Legislature

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ACKNOWLEDGMENTS

This is the second in a series of studies requested by Senator Joel Gougeon, Chairman of the Senate Appropriations Subcommittee on Community Health, to assess the effect of managed care and funding levels on the fiscal status of Michigan Medicaid health care providers. A sincere thanks to Brenda Fezatte and her crew at the Medical Services Administration Unit of the Department of Community Health and to Pam Yeomans, our secretary, who suffered through an endless stream of edits in finalizing this paper.

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ABSTRACT

A recent paper[1] by the Senate Fiscal Agency (SFA) found little support for the claim that the shift to managed care for the State's Medicaid program has produced sizable losses for the medical care provider community. However, as a macro level of analysis it did not address the issue of whether the Medicaid program, in and of itself, was underfunded. To assess that claim, the SFA gathered a considerable amount of hospital financial and related data and analyzed the data from a number of different perspectives. The results, based on that analysis, can be summed up as this: Michigan hospitals (as an industry) have lost, are losing, and will continue to lose money on patient services. However, these same hospitals, on average, make money on Medicaid patient services. There are two clearly identifiable reasons that hospitals are losing money. First, at any given time, more than 40% of all Michigan hospital beds are empty. Second, of those beds that are occupied, almost 50% are filled with persons covered by Medicare as compared with about 14% utilization by Medicaid recipients. Combining this with significant reductions in Medicare reimbursement caused by the Federal Balanced Budget Act of 1997 (BBA) does place many hospitals in financial jeopardy. However, the available data just does not support claims that Medicaid hospital payment rates are a significant cause of the financial dilemma many hospitals find themselves in today. While Medicaid outpatient rates are certainly at the low end of the payments scale, aggregate inpatient payments more than offset that deficit. A full and reasoned understanding of the dynamics affecting Michigan hospitals today may result in better problem resolution in the future.

BACKGROUND

Despite actions already taken and proposed by the Senate, House, and Administration, the hospital industry continues to insist that these efforts ". . . have not been sufficient to overcome what have become insurmountable [Medicaid] under-funding and program management problems."[2] The industry continues on by opining that a failure to address these issues immediately will result in further hospital closures; more layoffs on top of the 10,000 hospital employees who have already lost their jobs over the last 15 months; and increasing difficulty in obtaining care, not only for those on Medicaid, but also for other residents in affected communities.

In all fairness, it is noted the most recent testimony of the Michigan Health and Hospital Association (MHA) did not repeat recent claims that the transition to Medicaid managed care was costing the hospital industry hundreds of millions of dollars in losses. Also, for the first time, MHA's testimony began to give a weighting to the significant Medicare reductions contained in the Federal Balanced Budget Act of 1997. Nevertheless, MHA states that its member hospitals are providing in excess of $665 million in uncompensated care annually and that this amount is expected to grow as the number of uninsured persons in Michigan increases. The Association's latest testimony concluded with the belief that the hospital portion of the Medicaid budget needed to be increased by $122.6 million for Fiscal Year (FY) 2000-01: in other words, a 16.4% increase above the amount already enacted for hospital services and therapy in FY 2000-01.

In a recent paper the Senate Fiscal Agency found that Medicaid expenditures, after adjusting for actual changes in caseload, case mix and reasonable inflation assumptions, did not support claims that Medicaid managed care, in and of itself, was causing the Medicaid provider community significant financial losses. However, that study was based on a macro analytic model that compared aggregate Medicaid expenditures (for those medical services most associated with managed care) with projected levels of expenditures. As such, the study addressed the magnitude

of effect, if any, of the shift to managed care on provider revenue. The study discussed in this paper will attempt to describe and assess the financial status of the hospital industry as it relates to Medicaid funding *and* other sources of revenues and expenses.

If Medicaid has been underfunded, then the argument for increases to hospital providers becomes stronger. While the switch over to managed care may not have caused hundreds of millions of dollars in losses for hospitals, it could very well be true that these providers have been losing money all along on Medicaid services.

METHODOLOGY

Given the complexity of hospital finances and the variables that affect the industry's bottom line (gross patient revenue, contractual discounts, uncompensated care, occupancy, source of payment, etc.), the SFA undertook a series of analyses of hospital-related data, in order to assess the issues from as many perspectives as was reasonable. The foci of these analyses were:

- A comparison of hospital Medicaid revenues and costs with hospital net patient revenue from all sources.
- An analysis of year-to-year differences in selected hospital financial variables and an examination of factors that may explain any observed differences.
- A quantitative/qualitative assessment comparing hospital-specific financial data with media-reported difficulties of selected hospitals.
- Changes in hospitals' finances and their effect on hospital employment.
- A review of hospital uncompensated care and its possible impact on hospitals' financial status.

In performing these analyses, the SFA used data contained in the 1994, 1998 and 1999 "Fiscal Status of Michigan Hospitals" reports, the FY 1993-94 and FY 1997-98 Medicaid fee-for-service inpatient and outpatient revenue and cost reports, and hospital-reported uncompensated care for 1994, 1996, 1997, and 1998. It needs to be noted that these data sets were generated by the Department of Community Health (based on data submitted by hospitals) and have not been independently validated. However, most gross revenue data (especially related to Medicaid) are consistent with payment data contained in the State's accounting system. Where other data sources are used, e.g., hospital employment data derived from the Bureau of Labor Statistics, appropriate cites are given. The remainder of this section explains the process used for each level of analysis.

The first tier of analysis was to look at actual Medicaid fee-for-service expenditures and costs, by hospital, for fiscal years 1993-94 and 1997-98 (the latter being the latest year for which data are available). These data sets give a clear indication of how hospitals are faring with Medicaid payments as compared with how they are faring with other payers. This information was combined with financial data from the global data contained in the 1994, 1998, and 1999 "Fiscal Status of Michigan Hospitals" reports to lead to a view of the overall hospital fiscal situation.

A second approach looked at hospital finances by examining the "Fiscal Status of Michigan Hospitals" reports from 1994, 1998, and 1999 and making comparisons among the three years. One way of looking at the data was to compare hospitals that were profitable in a given fiscal year with the ones that were not profitable. Another method used was to look at relationships among various explanatory variables (such as Medicaid volume, Medicare volume, and bed occupancy) and a hospital's bottom line. The final view was to examine the global trend in the fiscal status of hospitals and look for possible explanations for any trend so found.

A third approach, admittedly more qualitative, was to look at information within these data sets and combine that information with outside reports from the media to try to explain the fiscal situations of hospitals whose financial problems have been in the news.

A fourth analysis was to assess the validity of the claim that Michigan hospitals have laid off 10,000 workers in the last 15 months. As Michigan health- and hospital-related employment is tracked month by month, the SFA was able to examine actual employment trends to address this issue.

For the final perspective, the SFA analyzed data on uncompensated care. In this case the data set was not as solid as the data used in the above examinations, as the components of these data may not have been standardized across all hospitals. However, the SFA was able to use data from 1997 and 1998 in order to examine the question of whether there had been a significant increase in uncompensated care.

RESULTS

Hospital Revenues and Expenditures

As a means of establishing a global perspective on hospitals' financial status, Table 1 displays the basic components of the "bottom line" for the industry.

Table 1

HOSPITAL FINANCES

	FY 1993-94	FY 1997-98	FY 1998-99 *	Change from FY 1993-94 to FY 1998-99
Gross Patient Charges	$17,982,624,600	$22,944,271,500	$24,430,705,200	$6,448,080,600
Contractual Allowances/Discounts	(6,860,864,500)	(9,280,363,400)	(10,285,125,300)	(3,424,260,800)
Net Patient Revenue	**$11,121,760,100**	**$13,663,908,100**	**$14,145,579,900**	**$3,023,819,800**
Total Operating Expenses	(11,259,606,500)	(14,037,910,000)	(14,766,248,100)	(3,506,641,600)
Net Income from Patient Services	**$(137,846,400)**	**$(374,001,900)**	**$(620,668,200)**	**$(482,821,800)**
Net Effect of Other Expenses	(132,187,800)	5,463,100	(50,659,600)	81,528,200
Other Income	632,162,200	1,226,533,700	1,187,803,800	555,641,600
Net Income	**$362,128,000**	**$857,994,800**	**$516,476,000**	**$154,348,000**

* FY 1998-99 data reflect latest available annual data from each hospital. Generally these are hospitals with fiscal years ending between July 1, 1998 and June 30, 1999.

Source: "Fiscal Status of Michigan Hospitals" reports

These data make certain obvious statements about Michigan hospital finances. While total patient charges rose over 35% from 1994 to 1999, the loss from patient services increased by nearly 350%. Only by adjusting for other income (investments, gifts, etc.) does the hospital industry's

bottom line show a profit. Though net income did climb by slightly less than 43% from 1994 to 1999, it dropped by 40% from 1998 to 1999 (though net income was still above the 1994 level).

In looking at these numbers, one would be hard pressed to say that the overall financial position of hospitals has not deteriorated. However, these numbers provide little in the way of clues as to why this deterioration is occurring. It may be possible that these gross numbers mask certain explanatory variables observable at the hospital-specific level. While these aspects will be explored later, this section attempts to assess the degree to which Medicaid payments affect the hospital industry's negative net patient income.

A review of Table 2, displaying and comparing net hospital patient revenue with Medicaid hospital payments and costs, leads to certain inescapable conclusions as did the data found in Table 1. That is, if not for Medicaid payments, the overall financial status of Michigan hospitals would have been *worse*. For FY 1993-94 the net loss on patient services would have risen by $2.5 million and by $106.1 million in FY 1997-98. In effect, the Medicaid net revenue to hospitals in FY 1997-98 reduced the system-wide net loss from patient services by 22%.

Table 2

NET MEDICAID HOSPITAL REVENUE

	FY 1993-94	FY 1997-98	Change
Net Income from Patient Services	**$(137,846,600)**	**$(374,001,900)**	**$(236,155,300)**
Medicaid Inpatient Payments	1,002,405,300	861,662,400	(140,742,900)
Medicaid Inpatient Costs	(874,012,200)	(651,443,900)	222,568,300
Medicaid Inpatient Fee-for-Service Profit/Loss	**$128,393,100**	**$210,218,500**	**$81,825,400**
Medicaid Outpatient Payments	204,626,200	129,701,600	(74,924,600)
Medicaid Outpatient Costs	(330,466,100)	(233,797,300)	96,668,800
Medicaid Outpatient Fee-for-Service Profit/Loss	**$(125,839,900)**	**$(104,095,700)**	**$21,744,200**
Total Medicaid Hospital Fee-for-Service Profit/Loss	**$2,553,200**	**$106,122,800**	**$103,569,600**

Source: "Fiscal Status of Michigan Hospitals" reports and Medicaid Fee for Service Inpatient/Outpatient Profit/Loss Comparison reports

Having said this, there are a number of qualifiers that must be noted. The first revolves around the fact that much of the observed Medicaid net profit comes from the inclusion of Graduate Medical Education (GME) and Medicaid Disproportionate Share Hospital (DSH) revenues that are not paid to all hospitals. As such, with these payments, even if Medicaid hospital base payment rates are inadequate, the State has provided additional funding pools (and has done so for years) to ensure that hospitals, especially those with the highest Medicaid burden, do not lose money on Medicaid.

Another concern is that, as there are no comparable Medicaid data for FY 1998-99, it could therefore be argued that the overall worsening of hospital finances seen for that fiscal year is a result of low Medicaid reimbursement rates. Until these data are available the only response is that there is no identifiable factor that would produce a *significant* change in the Medicaid reimbursement/cost relationship on a single year-over-year basis. As an example, even if it were assumed that hospitals' pharmacy costs jumped by 20% in one year, the change in net Medicaid inpatient revenue would be less than a $15.0 million year-over-year reduction.

One could also argue that, while hospitals make a profit on Medicaid fee-for-service, they are losing money overall due to Medicaid managed care. The SFA's recent report would indicate strongly that this is not likely. One can, however, construct an academic exercise to examine the possibility of a net loss related to Medicaid managed care.

The SFA reviewed HMO cost reports as a means of estimating the amount of hospital inpatient and outpatient payments made by Medicaid managed care plans. The estimate so generated, indicates payments of $225 million on the inpatient side and $115 million for outpatient hospital services[3]. As a related cost proxy, the ratio of Medicaid fee-for-service inpatient cost to revenue (adjusting for GME and DSH payment, a basically "breakeven" scenario) was applied to the estimate of inpatient managed care payments. The same process was applied to the relevant hospital outpatient data. The results of this exercise are displayed in Table 3.

Table 3

MEDICAID FEE-FOR-SERVICE AND ESTIMATED MANAGED CARE PAYMENT TO HOSPITALS FY 1997-98

	Fee-for-Service	Managed Care	Total
Medicaid Inpatient Payments	$861,662,400	$225,000,000	$1,086,662,400
Medicaid Inpatient Costs	(651,443,900)	(228,074,500)	(879,518,400)
Medicaid Inpatient Profit/Loss	**$210,218,500**	**$(3,074,500)**	**$207,144,000**
Medicaid Outpatient Payments	$129,701,600	$115,000,000	$244,701,600
Medicaid Outpatient Costs	(233,797,300)	(207,296,500)	(441,093,800)
Medicaid Outpatient Profit/Loss	**$(104,095,700)**	**$(92,296,500)**	**$(196,392,200)**
Total Medicaid Profit/Loss	**$106,122,800**	**$(95,371,000)**	**$10,751,800**

As is evident, total hospital revenue from Medicaid is still positive even when adjusted for the estimated net revenues hospitals receive under Medicaid managed care. Still, a concern could be raised that the cost/revenue relationship is different under managed care. One response is that indeed this relationship under managed care is different than that found in fee-for-service. To wit, most studies show that managed care enrollees are *less costly* than fee-for-service recipients. However, to follow the original question, the SFA altered this relationship and found that managed care inpatient and outpatient payments would *each* have to be reduced to 85% of the original estimate *while holding costs constant* before the loss from Medicaid (relative to the losses from other payers) was proportionate to the ratio of Medicaid payments to all other payers, or about 10%.

Before leaving this section, one final look behind these global numbers needs to be taken. As found in Table 1, gross patient charges have been significantly greater than net patient revenue. This results in an adjustment to gross charges (before netting out expenses) of an item referred to as "contractual allowances and discounts". The obvious question is: Where does this number come from? Each hospital is required to have a master charge schedule so that a patient in any given hospital is billed the same amount for the same services received by any other patient. How each hospital establishes its master charge schedule is probably rooted somewhere in antiquity. One thing that is certain, however: The majority of third party payers (Medicare, Medicaid, Blue Cross/Blue Shield, etc.) have not reimbursed at gross charges for years. As such, while hospitals may talk in terms of charges, their expectations as to the actual amount of payments that they will receive from any given payer are somewhat less.

Because the purpose of this paper is to explore what impact Medicaid payments have on Michigan hospitals, it is instructive to look at this reimbursement-to-charge relationship across payers. Table 4 takes this measure and displays some interesting results. Despite conventional wisdom that Medicaid is the payment laggard in terms of hospital payments, it appears that this distinction falls to Medicare. Further, the difference between Medicare and Medicaid is even more marked when its component parts are examined. When actual Medicare inpatient revenue is compared with its related gross charges, the resultant percentage is 54.8%. This compares with 72.3% when the same relationship is measured for Medicaid. Only when these measures are calculated for outpatient services does Medicare come out ahead: 31.2% (39.0% if the estimated Medicare co-payment is included) versus 29.8% for Medicaid (see Addendum).

Table 4

COMPARISON OF HOSPITAL GROSS CHARGES TO NET PATIENT REVENUE FY 1997-98

	Gross Patient Charges	Net Patient Charges	Net Revenue to Gross Charges
Medicaid	$1,628,909,000	$991,364,300	60.9%
Medicare *	8,667,031,900	4,374,560,600	50.5
Other	12,648,330,600	8,267,983,200	65.4
Total	**$22,944,271,500**	**$13,633,908,100**	**59.4%**

* includes Medicare co-pays

It should be noted that the revenue/charge ratio is higher for the "Other" category than for either Medicaid or Medicare. In addition, if the value of the estimated uncompensated care (a net $746.4 million) is removed from "Other", its revenue-to-charge ratio is an increase from 65.5% to 69.1%. On the other hand, the State also funds, directly or otherwise, a number of other programs, e.g., Wayne County indigent medical and the State Medicaid programs that provide revenue to Michigan hospitals, which most likely appear in the "Other" category and are not credited to Medicaid. When all is said and done, this section shows that first, Medicaid is a relatively small part of hospital finances. Second, hospitals made $100 million in profit on Medicaid fee-for-service in FY 1997-98, and third, in terms of revenues to charges, Medicaid is in the middle of the pack while one of the big players, Medicare, is trailing the field.

Explanatory Variables Affecting Hospital Finances

The previous section makes it clear that on a global basis, Medicaid is simply not a major factor in hospital finances. In order to examine further the impact of Medicaid, what the SFA did was to divide hospitals into two groups, based on four ways of looking at the FY 1997-98 and FY 1998-99 data. The first comparison was between hospitals that had net losses in FY 1998-99 and those that showed a net gain. The second was between hospitals that had such losses in FY 1997-98 and those that showed a net gain. The third comparison was between hospitals that had net losses on services to patients in FY 1998-99 versus those with net gains, and the fourth and final comparison was between hospitals with such losses in FY 1997-98 and those with net gains. Due to the unavailability of FY 1998-99 Medicaid revenue data, FY 1997-98 Medicaid data were used in all tables. The results are displayed in Table 5.

Table 5

COMPARISON OF HOSPITALS THAT LOST MONEY WITH HOSPITALS THAT MADE MONEY				
Hospitals with Net Overall Losses:	**Hospitals with Net Losses[1] in 1999**	**Hospitals w/o Net Losses in '99**	**Hospitals with Net Losses in 1998**	**Hospitals w/o Net Losses in '98**
Gross charges in given year[3]	$8,243,232,700	$16,187,472,500	$4,786,659,500	$18,157,612,000
Overall net revenue in given year gain/loss[4]	(249,023,700)	765,499,700	(211,401,000)	1,069,396,200
Patient care net revenue in given year gain/loss	(599,552,000)	(21,116,200)	(455,663,500)	81,661,600
1998 Medicaid care net gain/loss[5]	**$54,206,200**	**$51,916,600**	**$45,081,100**	**$61,039,500**
Total days of care in 1998[6]	2,086,406	4,162,380	1,326,503	4,922,283
Medicaid days of care in 1998[7]	370,867	508,593	260,924	618,536
Medicaid profit per day of Medicaid care	**$146**	**$102**	**$173**	**$99**
Hospitals with Net Patient Care Losses:	**Hospitals with Loss on Patient Care in 1999[2]**	**Hospitals w/o Loss on Patient Care in 1999**	**Hospitals with Loss on Patient Care in 1998**	**Hospitals w/o Loss on Patient Care in 1998**
Gross charges in given year[3]	$17,103,796,200	$7,326,909,000	$11,306,654,800	$11,637,616,700
Overall net revenue in given year gain/loss[4]	156,331,400	360,144,600	104,547,300	753,447,500
Patient care net revenue in given year gain/loss	(781,880,100)	161,211,900	(578,319,600)	204,317,500
1998 Medicaid care net gain/loss[5]	**$79,118,300**	**$27,002,300**	**$89,413,100**	**$16,709,700**
Total days of care in 1998[6]	4,324,245	1,924,541	3,113,969	3,134,817
Medicaid days of care in 1998[7]	662,181	217,279	555,510	323,950
Medicaid profit per day of Medicaid care	**$119**	**$124**	**$161**	**$52**

[1] "Hospitals with net losses in year 1998 or 1999" refers to hospitals that had negative net revenue (net patient revenue plus other revenue less other expenses) in that year.

[2] "Hospitals with loss on patient care in year 1998 or 1999" refers to hospitals that had negative net revenue on patient care alone in that year.

[3] "Gross charges in given year" means total patient charges prior to any discounts or allowances.

[4] "Overall net revenue in given year" means the sum of the net revenue for all hospitals in the category (patient care revenue plus other revenue less other expenses).

[5] "1998 Medicaid net gain/loss" means the sum of the 1998 Medicaid profit/loss data for the hospitals in the given category (1999 Medicaid data not yet available).

[6] "Total days of care in year 1998" means the sum of the bed days in 1998 for the hospitals in the given category (1999 occupancy data not yet available).

[7] "Medicaid days of care in 1998" means the sum of Medicaid bed days in 1998 for the hospitals in the given category.

Data sources: DCH Hospital Reports

What is apparent is that the hospitals in *each* of the eight groups showed a net profit from Medicaid services. It did not matter whether the group examined had a net gain or loss on patient care or a net gain or loss overall; the hospitals still had a net gain from Medicaid. If Medicaid was a factor in hospital losses, one would expect that the hospitals that lost money also lost money on Medicaid. Even more interesting, the hospitals that lost money averaged more profit on Medicaid per day of care than did the hospitals that made money in three of the four groupings. It seems clear that the hospitals that lost money overall tended to do better, from a profit/loss perspective, under Medicaid than did the hospitals that made money.

The SFA also looked at the entire data set of hospitals from both FY 1997-98 and FY 1998-99 and looked at other possible explanatory factors for profits and losses (such as Medicaid share, Medicare share, and overall occupancy). One specific variable, hospital occupancy, seems to stand out. On a descriptive basis, in 1998 (the last year with complete data), Medicaid patients occupied about 14% of filled hospital beds and 7.9% of all hospital beds, filled or unfilled[4]. By contrast, Medicare patients occupied 48% of filled beds and 27% of all beds. In effect, a 1% change in Medicare reimbursement rates has as much impact on Michigan hospitals' bottom lines as does a 3.5% change in Medicaid reimbursement.

From a statistical perspective, the only correlative factor that showed significance was hospital occupancy. There was a clear, positive correlation between occupancy rate and net income per bed. In other words, the variable most strongly correlated with a hospital's profitability is bed occupancy. This was true whether the straight correlation was examined or whether a linear regression incorporating several variables was run.

The next most strongly correlated variable (in an inverse way and not nearly as statistically significant as overall occupancy) was not Medicaid share of beds, but rather Medicare share of beds. The larger the Medicare volume, the more likely a hospital was to have net losses. From what has been seen so far, it was not surprising to find that Medicaid volume was slightly positively correlated with net income. In other words, the larger a hospital's Medicaid volume, the more profitable it was. This was true whether one looked at correlations or used a linear regression. Again it should be noted, the Medicaid correlation was not statistically significant. If Medicaid volume were a major factor in hospital losses, however, one would expect a somewhat statistically significant negative coefficient rather than a positive one.

The SFA believes that the hospital financial data reported by hospitals to the State once again raises serious questions as to the validity of the claim that the State's Medicaid program has underfunded hospitals. There is no negative correlation between Medicaid volume and profitability; hospitals that lost money showed a profit on Medicaid. In fact, these hospitals made more money per Medicaid bed day than hospitals that made money; and FY 1997-98 data indicate that hospitals made a net profit on patient care from Medicaid fee-for-service of over $100 million, in contrast to net losses on patient care of almost $500 million from other payers.

Given that there has been no significant decline in payments to Medicaid providers since the implementation of managed care and no sign of Medicaid hospital underfunding, it is clear that the answer to any financial difficulties for Michigan hospitals must lie elsewhere.

Hospital-Specific Assessment

The results of the above analysis beg the question: "What is going on with hospital finances?" Table 1 above shows the change from FY 1997-98 to FY 1998-99 in Michigan hospitals' financial position.

In FY 1997-98 net income from services to patients was roughly a negative $375 million, but, thanks to other income, net income for hospitals as a whole was close to a positive $860 million. In FY 1998-99 there was a worsening of hospitals' financial picture, as net income from services to patients dropped to a negative $621 million and net income dropped to a positive $516 million. The question keeps coming back: If Medicaid is not the problem, then why are the financial positions of Michigan hospitals worsening?

The answer, as is usually the case, is complex. One of the major factors appears to be the restraint built into Medicare expenditure growth in the 1997 Federal Balanced Budget Act. There have been a number

of statements by Michigan hospitals that reductions in the rate of growth of Medicare reimbursements have had a severe impact on hospital profitability. For instance, officials at St. Mary's Hospital in Saginaw state that the hospital has lost $2.3 million more in 1999 than in 1998 due to Medicare changes in the last year alone (Saginaw News, February 4, 2000). If this number were accurate, then projecting that value across the entire State would imply a $158 million reduction in actual revenues due to Medicare changes from 1998 to 1999.

As has been shown, a second factor is probably occupancy. The hospitals facing the greatest financial stresses have usually had occupancy problems. For instance, officials at Saline Community Hospital, in discussing whether the inpatient portion of the facility will remain open, state that the hospital has an occupancy of about nine patients per day out of 82 beds (Ann Arbor News, February 11, 2000). The article also refers to the Oakwood Hospital Beyer Center in Ypsilanti, which is slated for closure in April.

Occupancy data for the two facilities are on point: Saline hospital, in FY 1997-98, had an occupancy of 24%, with a Medicaid occupancy of 0.34% (or about a grand total of 100 Medicaid patient days per year). The Beyer Center had an FY 1997-98 occupancy rate of 28%, with a Medicaid occupancy of about 3%. It is very difficult to argue that Medicaid payment rates have had anything to do with these two facilities' financial problems, while it is very easy to argue that occupancy rates have plenty to do with the facilities' difficulties.

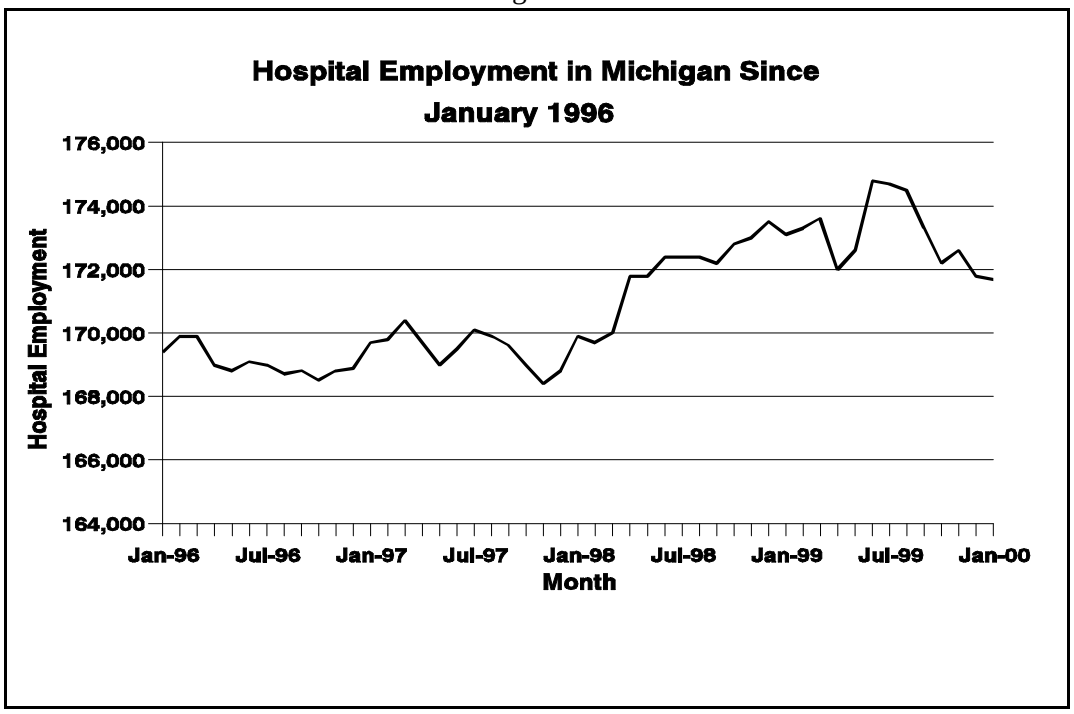
This is doubly so when it is found that both hospitals have a high Medicare volume (roughly 58% of occupied beds, as opposed to the statewide average of 48%). The combination of low overall occupancy and Medicare changes has likely been a major factor in both facilities' financial problems.

Hospital Finances and Employment

Another issue that has been raised is the effect of hospital closures and staff downsizing on employment. In its testimony before the Senate Appropriations Subcommittee on Community Health, the Michigan Health and Hospital Association stated, "in the last 15 months alone, some 10,000 hospital employees have lost their jobs."

The SFA sees no reason to question the claim that there have been 10,000 layoffs in the hospital industry over the last 15 months. However, an examination of the employment data indicates that the hospital employment picture has been more fluid than a simple claim of 10,000 layoffs would indicate.

Figure 1



As Figure 1 shows, hospital employment has fluctuated between 168,000 and 175,000 over the last four years, with no changes anywhere near the magnitude of 10,000 layoffs. There have been seasonal ups and downs, but there is no sign of a massive net reduction in hospital employment. In addition, the Federal BBA has had a much greater negative impact on home health agencies than it has had on hospitals[5]. To the extent that any of these agencies are hospital-based and their staffs are recorded as hospital employees, any observed downward trend in hospital employment could partially reflect this artifact.

Uncompensated Care and the Uninsured

Hospitals have historically provided care for which they receive no direct compensation. One of the claims made is that this care is on the increase and has had a role in the worsening of hospitals' financial situations. This claim is often tied to claims that the number of uninsured persons is on the increase and that the amount of uncompensated care will increase in the future.

The SFA has examined data, reported by hospitals, on uncompensated care, from 1997 and 1998. Clearly it is difficult to argue that there has been a significant increase in uncompensated care. The Hospital Association claimed that its facilities performed roughly $700 million in uncompensated care and the reported data that the SFA has examined are in that range (as shown in Table 6).

Table 6

HOSPITAL NET UNCOMPENSATED CARE AS A PERCENT OF TOTAL CHARGES					
Fiscal Year	Gross Uncompensated Care	Less: Recoveries and Payments	Net Uncompensated Care	Gross Hospital Charges	Net Uncompensated as % of Total
FY 1996-97	$859,608,400	$142,205,000	$717,403,300	$21,195,515,100	3.38%
FY 1997-98	881,155,400	134,709,300	746,446,100	22,944,271,500	3.25

Source: Quarterly self-reporting by hospitals to the Department of Community Health

The amount of uncompensated care actually increased from 1997 to 1998 but decreased as a percentage of gross charges. It is difficult to argue that uncompensated care has been on the increase. As has previously been noted, the amount of uncompensated care is self-reported by individual hospitals and can reflect charges for anything from care provided to those who are truly uninsured to poor billing and/or collection practices. Whatever the case, uncompensated care so reported almost certainly reflects "gross charges". At best, hospitals would expect to receive no more than 70% of these charges and, if they were compensated at the Medicare rate, it would be closer to 50% or somewhere in the area of $350 million. While a loss is a loss, this equates to less than 2.5% of net patient revenue.

CONCLUSION

After examining the relevant data, the SFA can find little evidence that the State's Medicaid program has underfunded hospitals. Hospitals made a net profit from Medicaid fee-for-service in the most recent year data reported, even when one recognized the low level of outpatient payment rates. Even if the approximate net profit and loss on Medicaid managed care is included, hospitals are still projected to show a net profit on Medicaid services. One must also note that the SFA has already concluded that there is no evidence to support the claim that there were massive losses caused by the shift to managed care.

Further examination of hospital financial data indicates that there are two possible explanations for the worsening financial situation of hospitals, both individually and collectively: The low occupancy rate in some hospitals and reductions in the rate of growth of Medicare reimbursements due to the 1997 Federal Balanced Budget Act. Neither of these explanations is related to Medicaid, but both have anecdotal as well as statistical evidence to support them.

An examination of hospital employment data indicates that, while there may have been 10,000 layoffs over the last 15 months (as has been claimed), there have been enough hirings that the level of hospital employment is still within the same 168,000-175,000 band that it has been in over the past few years.

Finally, an examination of noncompensated hospital care shows no indication that uncompensated care is showing a significant increase. Furthermore, there are a number of reasons, beside services provided to the uninsured, for hospitals to have bad debt. Also, even if hospitals were able to collect on these at the same rate they collect from Medicare, the amount would be no more than 2% to 3% of net revenue.

The purpose of this paper has been to explore as many avenues as possible to develop an understanding of why Michigan hospitals seem to be in such dire financial shape. There is no doubt that the hospital industry has its troubles and that things will probably get worse before they get better. There is a real possibility that additional hospitals will close and to the extent that some are considered critical access hospitals, they may require governmental subsidies to remain viable. However, while the

State governments may be able to stem some of the hospitals' bleeding through increases in outpatient payment rates and other marginal changes in the Medicaid payment system, the data clearly seems to be saying that unless hospitals make systemic changes to alter their low occupancy rates and find a way for taking the real culprit, Medicare, head on, Michigan hospitals could be headed for a real catastrophe.

END NOTES

1. Walker, J.S., and Angelotti, S.: An Examination of the Impact of Managed Care on Medicaid Provider Revenues. *Senate Fiscal Agency Issue Paper, February, 2000.*

2. Testimony of Michigan Health and Hospital Association before the Michigan Senate Appropriations Subcommittee on Community Health, February, 8, 2000.

3. Annual statements for calendar year 1998 and first three quarterly statements for calendar year 1999 filed by all Health Maintenance Organizations with the Michigan Insurance Bureau.

4. 1998 Hospital Occupancy and Utilization with Statewide Averages. Generated from 1998 Fiscal Year Cost Reports.

5. Seifert, M. L., Heffler, S.K., and Donham, C.S.: Hospital, Employment, and Price Indicators for the Health Care Industry: First Quarter, 1999. *Health Care Financing Review, Volume 21, Number 1, Fall 1999.*

ADDENDUM

As one can surmise from the very low Medicaid reimbursement-to-charge percentage for outpatient services, almost all hospitals take a loss on these services. Even though these losses are offset by gains on inpatient services, there are still hospitals that experience losses from both inpatient and outpatient services. During the period of time that this paper was under development, the Senate Subcommittee on Community Health was also in the process of building the Senate version of the FY 2000-01 budget for that Department. These two concurrent activities have resulted in a Senate action to differentially update hospital payment rates by increasing outpatient reimbursement at a higher percentage than inpatient services. In effect, the funding increase in the current year, and that proposed by the Senate for the coming year, will have the most positive effect on the area of Medicaid payments that have been most problematic for Michigan hospitals.

If the increases in the Senate passed bill are eventually signed into law, the aggregate 2 year increase in revenues to hospitals will be over $60 million. While it will not eliminate the total Medicaid based outpatient losses, it will reduce the magnitude by over 35%, holding all other things constant. In addition, the hospitals should also receive a $23.5 million increase in fee-for-service inpatient revenue. As has previously been shown, aggregate Medicaid inpatient payments already produce a net gain for the hospital industry and this increase should further bolster that fact.